

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

4851

1. PLACE OF DEATH

County Jackson

Registration District No. 399

File No. _____

Township Ram

Primary Registration District No. _____

Registered No. 444

City Kansas City (No. Kansas City Central Hosp.)

St. _____ Ward _____

2. FULL NAME

Boat Leonard

(a) Residence. No. Jackson County Home St. _____ Ward _____

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

J M Booth

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-27-1873

7. AGE

YEARS

58

MONTHS

9

DAYS

5

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Asst Supt.

(b) General nature of industry, business, or establishment in which employed (or employer)

Jackson Co Home

(c) Name of employer

County Court

9. BIRTHPLACE (CITY OR TOWN) Jackson, Mo

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER

John U. B. Martin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Caroline Martin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

14.

INFORMANT

(Address)

Record Clerk
Kansas City Gen. Hosp.

15.

FILED

3, 1930 M. M. Crove

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-2-1930

17. I HEREBY CERTIFY, That I attended deceased from 2-1-1930, to 2-2-1930, that I last saw her alive on 2-2-1930, and that death occurred, on the date stated above, at 12:05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Epidemic cerebrospinal meningitis

18 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

24

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH. DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) P. E. Williams, M. D.

2-2-1930 (Address) Supt. K. C. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

Feb 4 1930

20. UNDERTAKER

ADDRESS

W. H. Mitchell

Indef Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

2030

